North West Anglia NHS Foundation Trust

REPORT TO THE TRUST BOARD (PUBLIC)

REPORT TITLE	Urgent and Emergency Care
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EXECUTIVE SPONSOR	Phil Walmsley, Chief Operating Officer
DATE OF MEETING	8 February 2022
PRESENTED FOR	Discussion
ITEM PREVIOUSLY CONSIDERED BY	N/A

Presented For: Definitions

Information	For information only. Not to be discussed at meeting unless members have specific questions.
Discussion	For discussion and possibly future decision. This includes items presented for assurance.
Decision	For approval and/or when any other decision is required

PURPOSE OF THE REPORT

North West Anglia NHS Foundation Trust ("Trust") is required to deliver against a series of urgent and emergency care (UEC) standards. The purpose of this paper is to provide the Trust Board with an overview of performance against current standards, progress made with plans for managing urgent and emergency care pressures over the winter surge period and our progress with implementation of the new urgent care standards expected to be in place from April 2022.

RISKS RELEVANT TO THE PAPER

Risk ID	Risk Description
103350	Risk of patient harm due to the Trust not sustaining effective patient flow which will negatively impact on waiting times, safety, patient and staff experience.
103349	As a result of the ongoing impact of COVID-19, there is a risk that the Trust is not able to safely restore all local and specialist services to previous levels of capacity which results in increased waiting times and poorer outcomes and experience for patients.

RISK APPETITE RELEVANT TO THE PAPER (insert relevant section from Risk Appetite Statement from Risk Management Policy)

DOMAIN	TRUST RISK APPETITE LEVEL	DESCRIPTION OF RISK APPETITE

THE BOARD IS ASKED TO:

1. The Board is asked to note current urgent and emergency care performance against existing indicators, new CRS indicators that are currently being reported in shadow form and against national benchmarking data.
2. The Board are asked to note the update on progress with implementation of the Trust's winter plan for 21/22 year to date and the risks associated with the plan as a result of the ongoing COVID-19 pandemic.

STRATEGIC GOALS THIS REPORT SUPPORTS *(Check all that apply)*

Delivering outstanding care and experience	✓
Recruiting developing and retaining our workforce	✓
Improving and developing our services and infrastructure	☐
Working together with local health and social care providers	✓
Delivering financial sustainability	☐

OTHER IMPLICATIONS OF THE PAPER

Legal/ Regulatory Relevance:	NHS England Single Oversight Framework
NHS Constitution Delivery	A&E four hour performance and A&E quality indicators
Freedom of Information Release	This report can be released under the Freedom of information Act 2000.

Equality and Diversity Implications *(Check all that apply)*

Age	Gender	Ethnicity	Disability	Pregnancy/ Maternity	Marriage/ Civil Partnership	Religion/ Belief	Sexual Orientation	Gender Reassignment
☐	☐	☐	☐	☐	☐	☐	☐	☐

Additional comments

1. Introduction and Background

1.1 Urgent care performance across the Trust has been below national constitutional standards since 2016, with A&E four hour performance along with other clinical quality measures below expected levels. Since 2019 the rate of decline in performance has been significant at Peterborough City Hospital (PCH) and from early 2021 we saw similar deterioration at Hinchingbrooke Hospital (HH).

1.2 Alongside existing urgent and emergency care indicators, the Trust has also implemented shadow reporting against a series of new indicators that will be introduced no later than April 2022. These revised indicators, developed following a national Clinically-led Review of Access Standards (CRS) in 2019[1] and further consultation document in 2020[2] are intended to demonstrate performance across urgent care pathways, commencing from pre hospital care.

1.3 The Trust has had and continues to have a series of improvement plans in place to improve urgent care performance, both internal and externally supported at a system level, recognising the collective challenge in managing front door demand, inpatient flow and discharge effectiveness across the community. While many plans to date have been delivered with achievement of the intended outcomes, the context we are working within continues to shift and these emerging and changeable pressures are contributing to ongoing challenges with delivery of UEC standards.

1.4 The Trust has reviewed and revised its internal governance arrangements for unplanned care recently and through the Unplanned Care Board has a clearer route for oversight and escalation. The unplanned care board reports into the System Resilience Group to provide assurance and to link with the wider Integrated Care System (ICS) level improvement work. It is here that the plans will demonstrate alignment to national policy including the UEC recovery 10 point action plan[3]. We also continue to work closely with regional and national ED improvement and delivery teams and individual subject matter experts to scrutinise our plans and ensure we are learning from elsewhere.

1.5 Factors contributing to poor performance across UEC pathways are both internal and external, with internal challenges around culture, leadership, capacity, resources and general effectiveness of processes to manage patient flow across the organisation. These are not new to the Trust or different to those experienced within the region and nationally in other Trusts. Bed occupancy is a critical factor in enabling flow through our EDs with our occupancy levels consistently exceeding the safe levels of 92% that the Trust is expected to deliver in line with the NHS Operational Planning Guidance[4]. From an external perspective, challenges in the wider NHS and care sector, workforce availability, increasing demand and limited supply are also impact on our ability to safely manage and deliver urgent and emergency care to the standards we would expect.

[1] https://www.england.nhs.uk/wp-content/uploads/2019/03/CRS-Interim-Report.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2020/12/Transformation-of-urgent-and-emergency-care_-models-of-care-and-measurement-report_Final.pdf

[3] Microsoft PowerPoint - UEC Recovery 10 Point Action Plan.pptx (england.nhs.uk)

[4] NHS England » NHS Operational Planning and Contracting Guidance

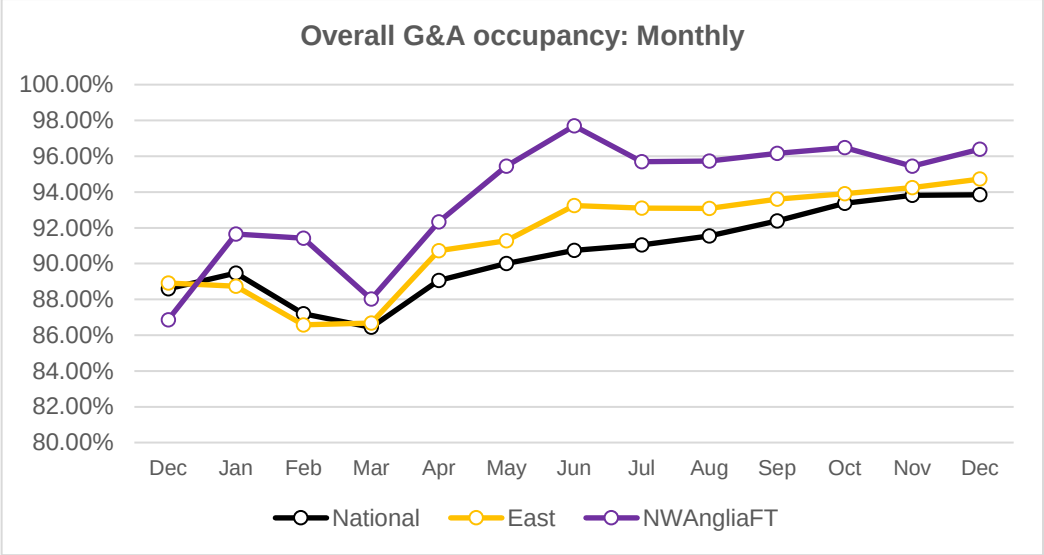

Chart one: Overall G&A occupancy monthly. Source: NHS England Weekly Hospital Activity

1.6 The COVID-19 pandemic has also had a significant impact on how the Trust manages patient flow, with ring-fenced capacity now required for isolation of patients impacting on our overall available bed base. We also believe we are seeing increased acuity among patients presenting to our Emergency Departments as an indirect consequence of the pandemic, with people waiting at home during periods of lockdown with worsening conditions, access to other services including primary care limited for periods and increasing long waits for outpatient, diagnostic or elective care services due to large scale cancellation and clinical prioritisation of services. Recent analysis indicates that Peterborough catchment areas remains with high levels of community prevalence of COVID-19 within its population which has a direct impact on capacity within the Trust.

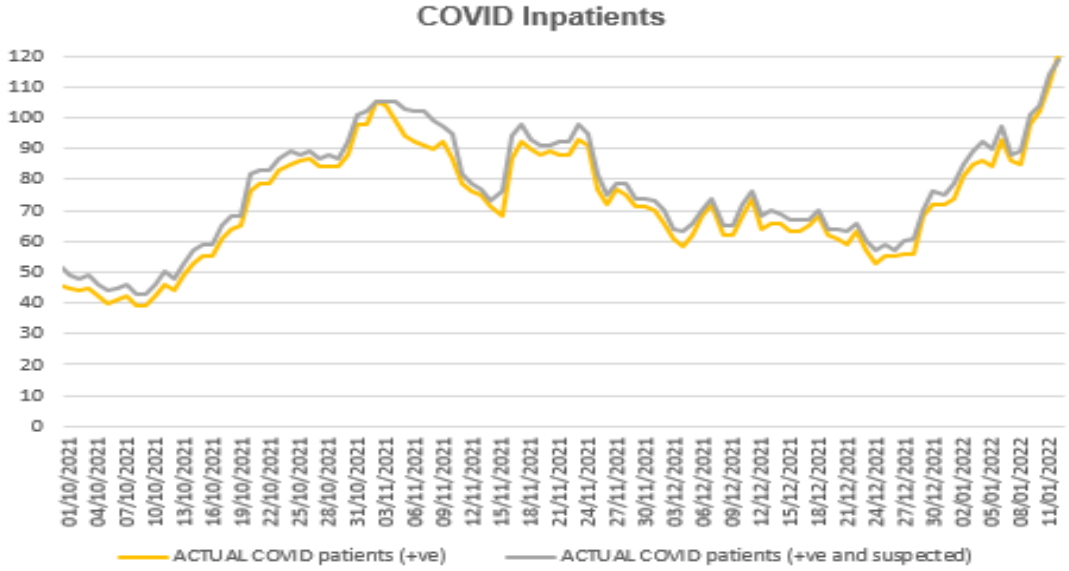

Chart two: COVID positive inpatients across NWAngliaFT hospitals. Source: Daily sitrep

1.7 We continue to see sickness absence levels among our staff exceed rates of previous years and above our expected levels for 21/22, for which we had already anticipated additional gaps as a result of COVID. This is not only in relation to actual sickness but the additional complexity of isolation. Again this is not unique to this Trust but yet

another challenge in an already busy winter and again the decline in these figures has yet to reach the Trust by comparison with other Trusts within the Region and nationally. These people pressures are being experienced across the health and care sector with workforce availability also a key factor in availability of services outside of the acute environment i.e. discharge and community capacity including the availability of domiciliary care. The challenges of the previous 18 months have also significantly impacted on the wellbeing of our staff. It is important we recognise this in the turnover and sickness measures as we prepare for the next few months.

1.8 It is widely recognised that the winter period for 2021/22 is considerably challenging for the health and care sector and as such numerous national funding streams have been identified to support organisations in maintaining core services during this period. The Trust had also earmarked £1.5m of internal investment for supporting winter schemes. While options for utilisation of this funding have been considered and mobilisation plans developed, it is likely that the workforce pressures outlined above will impact on the deliverability of these schemes.

2.0 Current Performance

2.1 An overview of our performance against all current key performance indicators for emergency care and against the new CRS standards, due to be introduced no later than April 2022, forms part of the monthly Integrated Performance Report.

2.2 Nationally performance against the four hour A&E waiting time standard is at its lowest ever level, with all providers struggling to meet increasing population demand and manage pressures across their capacity. However, within the national context, North West Anglia NHS FT is one of the worst performing organisations for the four hour A&E performance standard.

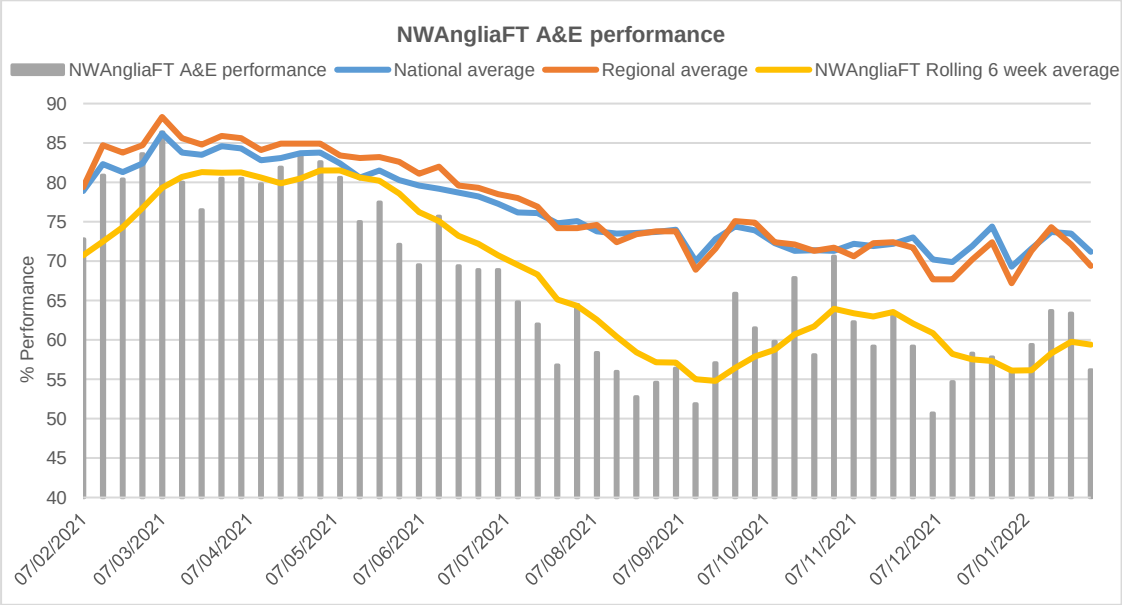

Chart three: NWAngliaFT A&E performance vs. regional and national performance averages. Source: NHS England A&E Daily sitrep

2.3 A&E four hour performance at a site level is variable. PCH performance has been significantly below standard for a sustained period of time (2019) and while there have been marginal improvements made in some months as a result of specific actions, our performance remains far below expected levels. At Hinchingbrooke Hospital we have seen a significant deterioration in performance in recent months.

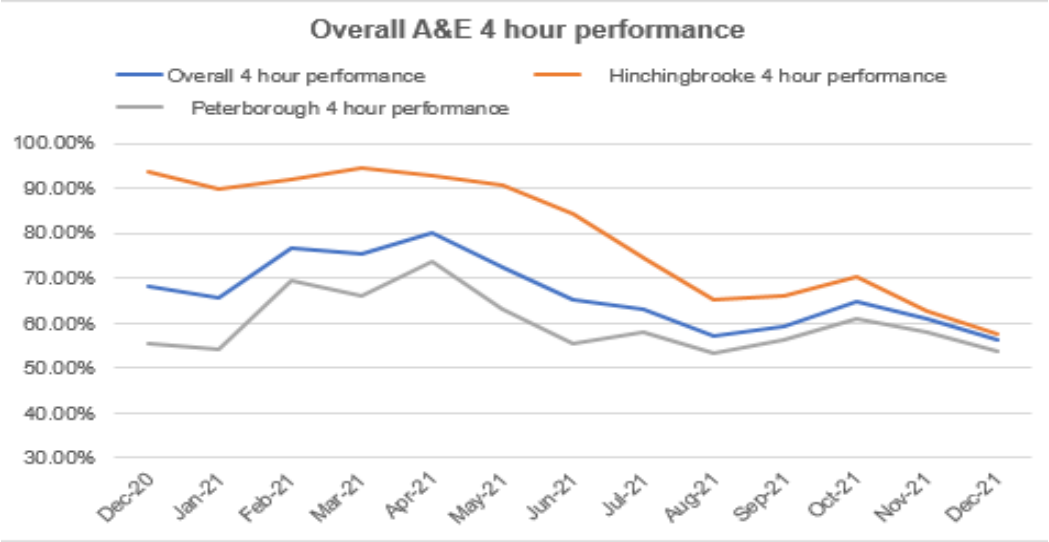

Chart four: A&E performance at site level. Source: Monthly A&E Sitrep

2.4 PCH performance has remained between 55-65% on average for the previous 24 months, the last time the site delivered consistently higher performance was during the wave two peak of the COVID-19 pandemic when the site had significantly lower bed occupancy and relatively good patient flow across our inpatient areas. Arrangements in place during this period, including standing down of other non-urgent and elective activity, enhanced discharge arrangements across community and local authorities, including additional commissioned capacity, ceased during April 2021. During April 2021 we also saw the relaxing of some lockdown restrictions with emergency activity increasing significantly (10% increase from March to April) and for Quarter one 2021/2022, a 39% increase in patients presenting to ED only when compared to Quarter four 2020/2021.

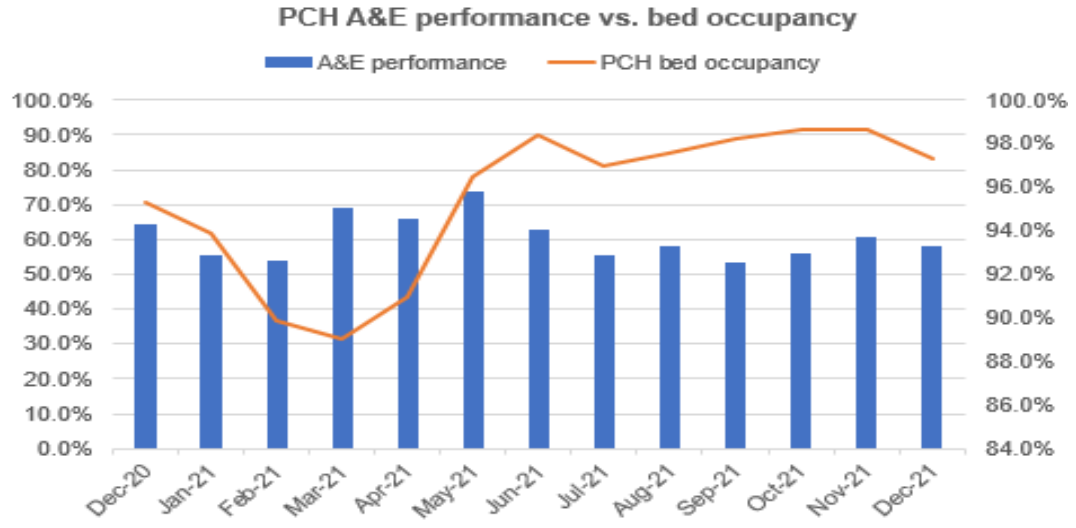

Chart five: PCH A&E performance vs. bed occupancy. Source: A&E monthly sitrep

2.5 At an organisational level, it is the deterioration of A&E four hour performance at HH since June 21 which has impacted on our overall Trust position and performance ranking nationally. Prior to June 21, HH site was routinely one of the best performing sites for A&E performance nationally, as supported by the SEDIT national benchmarking data where the site has been consistently ranked in the 4th quartile.

2.6 Drivers for the deterioration in performance at Hinchingbrooke include significant workforce challenges across both our nursing and medical workforce, exacerbated by Doctor changeover during August, a high number of leavers and insufficient recruitment to address underlying vacancy rates. This coupled with continued high presentations (above 21/22 activity plan and demonstrating c8-10% growth vs. pre pandemic levels) and occupancy pressures across our inpatient medical bed base has resulted in flow challenges through ED and a high number of patients breaching the four hour standard.

2.7 Given the pressures on the PCH site, it is also important to acknowledge that HH ED routinely provides a level of extended support beyond its original catchment area, resulting from both a formal ambulance boundary adjustment agreed earlier in 2021 which enables a greater number of conveyances from PCH catchment to go to HH and on a daily basis, operational decisions to load level both new presenting and existing inpatient demand across our two hospital sites in order to balance safety and quality of care for our patients.

2.8 Improvement plans specifically for HH site are in development and will form part of our overarching unplanned care governance arrangements.

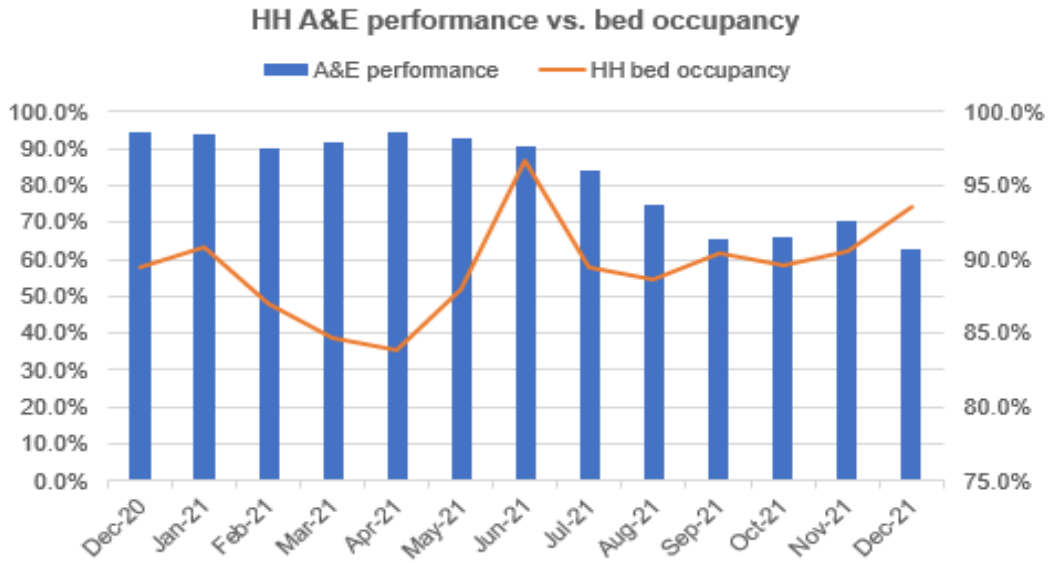

Chart six: HH A&E performance vs. bed occupancy. Source: A&E monthly sitrep

2.9 It is important to note that while A&E activity is broadly in line with plan for 21/22 at a Trust level, we have continued to see an increase in presentations to our other urgent and emergency care services including Same Day Emergency Care (SDEC) services, as shown within our Integrated Performance Report. We have continued to expand alternative services including SDEC as alternatives to patients presenting to our emergency departments (EDs), it is therefore important to consider the total volume of

patients presenting across these services in relation to the emergency pressures on our hospital sites. The increase in SDEC provision has enabled a reduction in non-elective admissions, with activity year to date 21/22 below plan.

2.10 Streaming patients to alternative services means that only acutely unwell major's patients should now remain in an ED stream. These patients are most likely to be admitted as an inpatient and as a consequence of bed occupancy challenges, the proportion of these patients waiting in ED in excess of 12 hours (new indicator), waiting more than 12 hours for their bed from decision to admit and average time in ED has increased, this is particularly evident on the PCH site. Overall, the Trust is reporting >8% of patients waiting for more than 12 hours in our Emergency Departments in December 2021.

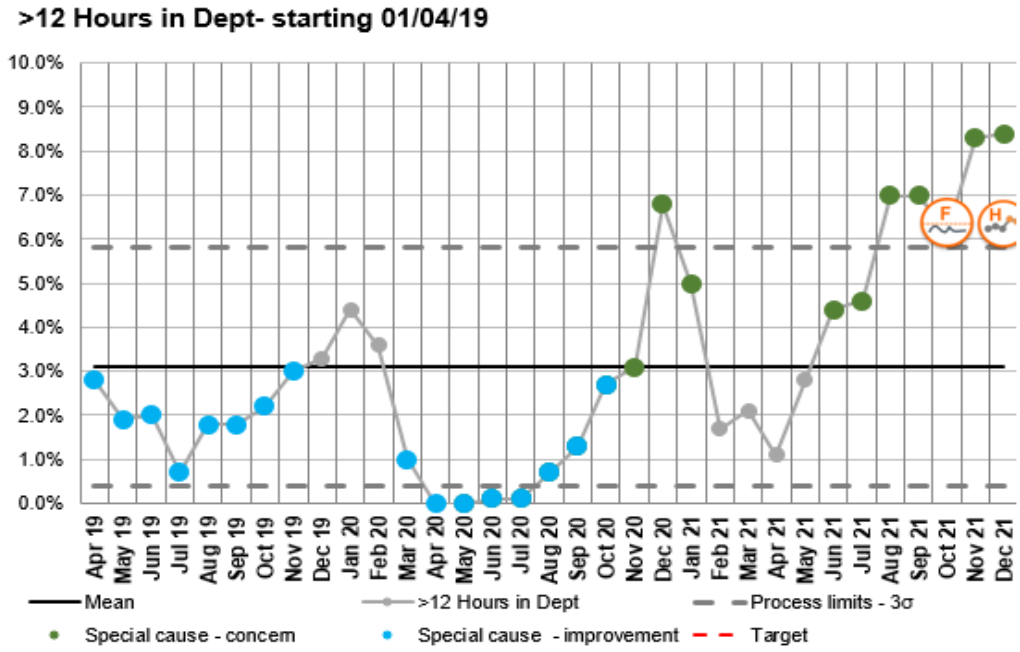

Chart seven: NWAngliaFT patients remaining in emergency department >12 hours. Source: A&E monthly sitrep

2.11 Our current performance against other new CRS indicators such as clinically ready to proceed (<1hour DTA) is also challenged though data quality concerns exist with the shadow data and accuracy of recording within ED. Gaps in assurance of recording and reporting will be addressed as part of our implementation plan. While the implementation date is not yet confirmed we anticipate the new standards being introduced no later than April 2022, at which point the existing four hour A&E waiting time standard will no longer be measured.

3. Winter Plans

3.1 The Trusts winter plan was shared as draft with Trust Board in November 2021. The plan focussed on a small number of key priority areas where we intended to both fund specific winter schemes and take supporting operational actions to manage through this surge period:

- Attendance avoidance and front door
- Urgent and emergency care pathways

- Inpatient flow and discharge
- People

3.2 Winter schemes are in place for a four month period, commencing from November / December 21 through to February / March 22. Delivery of winter schemes are heavily people dependant and work is ongoing with HR and recruitment teams to support shift fill. The Trust has committed c£600k of expenditure to support winter schemes year to date, of the original allocation of £1.5m. Work is ongoing to revise year end forecasts taking into consideration the impact of the Omicron COVID peak during December and January. A summary update on each element of the winter plan is shown in the table below:

	Updates / actions taken to date	**Further actions required**
Assumptions	• Winter assumptions, as included within the plan shared with Board in November, have been flexed in response to the rapidly changing COVID impact with higher than anticipated levels resulting in need to redeploy staff to support critical care surge on PCH site. • Staff absence remains >3% higher than planned levels due to the additional impact of high isolation numbers.	N/A
Operational actions	• Focus on revising and expanding escalation policies and plans to cope with levels of demand including introduction of new boarding policy and revised ambulance cohorting policy. • The planned step down of routine elective activity for first two weeks of January was extended in response to continuing COVID admissions, surgery and outpatients, where appropriate, to release staff to support non elective flow. • System wide reset event (Multi Agency Discharge Event) took place in second week of January 22. • 7 day senior operational and clinical cover established with on call arrangements extended to on- site cover during January and partial February.	N/A
Funded winter schemes	• Focussed activities underway to support rapid recruitment for admin and clerical staff as well as HCAs. • Inability to find staff, with continued higher than planned absence rate, will limit our ability to deliver many of the schemes to the maximum impact initially anticipated. Omicron impact through Dec/Jan significant.	Regular review of deliverability of all schemes with cross divisional agreement on repurposing resources in real time where practical

Governance and oversight	• Weekly oversight in place across all winter plan elements – real time decisions on redistribution / amendments to plan to maximise impact. • Bi-weekly reporting / updates via North SRG • Monthly reporting in place to HMC / Performance and estates committee.	Challenge with teams being able to code additional shifts to winter budget code. Extensive retrospective work would be required to map finances across.

3.3 There have also been several new national funding streams made available to the Trust in recent weeks to support elective and emergency care during winter. This additional funding is intended to be spend on additional insourcing and outsourcing of elective activity, supporting the ambition of achieving zero >104 week elective wait by end March 22. A proportion of the funding will also be committed to increase capacity for non-elective patients through winter, specifically increasing the Trusts available bed base in order to manage levels of presenting emergency demand. Plans for spending this additional external funding have been developed and approved via Investment Management Committee with regular reporting on delivery through relevant sub-board committees.

3.4 There has been considerable unknowns in planning for and taking actions to support operational delivery through this winter period. The certainty and scale of a likely further COVID wave was unknown as is the continued impact of the Omicron variant. While the national peak is believed to be behind us, we have seen and continue to see high local rates of COVID prevalence within our population and therefore we will need to continue to be responsive to operational and clinical needs across our services. As outlined earlier, there remains risks and issues relating to availability and resilience of our people, with sickness absence presenting a daily operational challenge in delivering services in line with expected levels. The Trust will also need to continue to work closely with partners through the North System Resilience Group (SRG) to refine and implement collective surge and improvement plans.

4.0 Conclusion

4.1 The Board is asked to note current urgent and emergency care performance against existing indicators, new CRS indicators that are currently being reported in shadow form and against national benchmarking data. The Board are asked to note the update on progress with implementation of the Trust's winter plan for 21/22 year to date and the risks associated with the plan as a result of the ongoing COVID-19 pandemic.